

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04966

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Queen Anne 4968 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Church Hill c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Centreville RFD d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Brown Last Brown		4. DATE OF DEATH Month April Day 12 Year 19-58	
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1910
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Brown	
14. MOTHER'S MAIDEN NAME Sarah Bordley		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Etta Tilghman Address Centreville, Md. RFD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE W. Henry Fisher		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED 4/14-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 15	22c. NAME OF CEMETERY OR CREMATORY Burrisville	22d. LOCATION (City, town, or county) (State) Centreville, Md. RFD
23. FUNERAL DIRECTOR'S SIGNATURE Edgar K. Kane		ADDRESS Church Hill, Md.	
24a. REC'D BY REGISTRAR APR 17 '58		24b. REGISTRAR'S SIGNATURE Quincy	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in pencil in the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, date, time, place, and cause of death. The form is oriented upside down.

BUREAU V. 3

APR 17 1969

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4969

CERTIFICATE OF DEATH

04967

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Church Hill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Church Hill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>R.</u> Last <u>Coleman</u>		4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 28, 1874</u>
9. AGE (In years (last birthday) yrs.) <u>83</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Wagonman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William R. Coleman</u>		14. MOTHER'S MAIDEN NAME <u>Octavia Ringgold</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>207-01-3794</u>	
17. INFORMANT <u>Mrs. Wm. R. Coleman</u>		Address <u>Church Hill Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 1-1958</u> to <u>April 1-1958</u> , that I last saw the deceased alive on <u>April 1-1958</u> , and that death occurred at <u>6:00</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. Henry Fisher</u>		M.D. <u>Centerville Md</u>	
PHYSICIAN'S NAME (Type) <u>W. Henry Fisher</u>		DATE SIGNED <u>4/3-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 4</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Crumpton</u>		22d. LOCATION (City, town, or county) (State) <u>Crumpton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>		ADDRESS <u>Church Hill, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Henry Fisher</u>	

CERTIFICATE OF DEATH

Form No. 10

1. NAME OF DECEASED JACKSON, JAMES		2. SEX M		3. AGE 45	
4. PLACE OF BIRTH BALTIMORE, MARYLAND		5. DATE OF BIRTH JAN 15 1910		6. PLACE OF DEATH BALTIMORE, MARYLAND	
7. OCCUPATION LABORER		8. CAUSE OF DEATH HEART DISEASE		9. MANNER OF DEATH NATURAL	
10. SIGNATURE OF DECEASED (None)		11. SIGNATURE OF WITNESSES JAMES J. JACKSON		12. SIGNATURE OF PHYSICIAN J. J. JACKSON	
13. SIGNATURE OF CLERK J. J. JACKSON		14. SIGNATURE OF REGISTRAR J. J. JACKSON		15. SIGNATURE OF DECEASED (None)	
16. SIGNATURE OF DECEASED (None)		17. SIGNATURE OF DECEASED (None)		18. SIGNATURE OF DECEASED (None)	
19. SIGNATURE OF DECEASED (None)		20. SIGNATURE OF DECEASED (None)		21. SIGNATURE OF DECEASED (None)	
22. SIGNATURE OF DECEASED (None)		23. SIGNATURE OF DECEASED (None)		24. SIGNATURE OF DECEASED (None)	
25. SIGNATURE OF DECEASED (None)		26. SIGNATURE OF DECEASED (None)		27. SIGNATURE OF DECEASED (None)	
28. SIGNATURE OF DECEASED (None)		29. SIGNATURE OF DECEASED (None)		30. SIGNATURE OF DECEASED (None)	
31. SIGNATURE OF DECEASED (None)		32. SIGNATURE OF DECEASED (None)		33. SIGNATURE OF DECEASED (None)	
34. SIGNATURE OF DECEASED (None)		35. SIGNATURE OF DECEASED (None)		36. SIGNATURE OF DECEASED (None)	
37. SIGNATURE OF DECEASED (None)		38. SIGNATURE OF DECEASED (None)		39. SIGNATURE OF DECEASED (None)	
40. SIGNATURE OF DECEASED (None)		41. SIGNATURE OF DECEASED (None)		42. SIGNATURE OF DECEASED (None)	
43. SIGNATURE OF DECEASED (None)		44. SIGNATURE OF DECEASED (None)		45. SIGNATURE OF DECEASED (None)	
46. SIGNATURE OF DECEASED (None)		47. SIGNATURE OF DECEASED (None)		48. SIGNATURE OF DECEASED (None)	
49. SIGNATURE OF DECEASED (None)		50. SIGNATURE OF DECEASED (None)		51. SIGNATURE OF DECEASED (None)	
52. SIGNATURE OF DECEASED (None)		53. SIGNATURE OF DECEASED (None)		54. SIGNATURE OF DECEASED (None)	
55. SIGNATURE OF DECEASED (None)		56. SIGNATURE OF DECEASED (None)		57. SIGNATURE OF DECEASED (None)	
58. SIGNATURE OF DECEASED (None)		59. SIGNATURE OF DECEASED (None)		60. SIGNATURE OF DECEASED (None)	
61. SIGNATURE OF DECEASED (None)		62. SIGNATURE OF DECEASED (None)		63. SIGNATURE OF DECEASED (None)	
64. SIGNATURE OF DECEASED (None)		65. SIGNATURE OF DECEASED (None)		66. SIGNATURE OF DECEASED (None)	
67. SIGNATURE OF DECEASED (None)		68. SIGNATURE OF DECEASED (None)		69. SIGNATURE OF DECEASED (None)	
70. SIGNATURE OF DECEASED (None)		71. SIGNATURE OF DECEASED (None)		72. SIGNATURE OF DECEASED (None)	
73. SIGNATURE OF DECEASED (None)		74. SIGNATURE OF DECEASED (None)		75. SIGNATURE OF DECEASED (None)	
76. SIGNATURE OF DECEASED (None)		77. SIGNATURE OF DECEASED (None)		78. SIGNATURE OF DECEASED (None)	
79. SIGNATURE OF DECEASED (None)		80. SIGNATURE OF DECEASED (None)		81. SIGNATURE OF DECEASED (None)	
82. SIGNATURE OF DECEASED (None)		83. SIGNATURE OF DECEASED (None)		84. SIGNATURE OF DECEASED (None)	
85. SIGNATURE OF DECEASED (None)		86. SIGNATURE OF DECEASED (None)		87. SIGNATURE OF DECEASED (None)	
88. SIGNATURE OF DECEASED (None)		89. SIGNATURE OF DECEASED (None)		90. SIGNATURE OF DECEASED (None)	
91. SIGNATURE OF DECEASED (None)		92. SIGNATURE OF DECEASED (None)		93. SIGNATURE OF DECEASED (None)	
94. SIGNATURE OF DECEASED (None)		95. SIGNATURE OF DECEASED (None)		96. SIGNATURE OF DECEASED (None)	
97. SIGNATURE OF DECEASED (None)		98. SIGNATURE OF DECEASED (None)		99. SIGNATURE OF DECEASED (None)	
100. SIGNATURE OF DECEASED (None)		101. SIGNATURE OF DECEASED (None)		102. SIGNATURE OF DECEASED (None)	

RECEIVED
APR 8 1958
BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4970 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Queen Anne MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Queen Anne	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Chestertown		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At home		d. STREET ADDRESS (Pondtown)	
3. NAME OF DECEASED (Type or print) Eliza Lurenia Johnson		4. DATE OF DEATH Apr. 27, 1958	
5. SEX female	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 29, 1893
9. AGE (In years last birthday) yrs. 65		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife & Laborer at cannery		10b. KIND OF BUSINESS OR INDUSTRY Kent Co. Maryland	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Thomas		14. MOTHER'S MAIDEN NAME Eliza Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name (known) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 218-16-8092	
17. INFORMANT Walter Johnson		Address Chestertown, Md. RFD (Queen Anne Co.)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO occlusion, Medically Corroborated Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Corroborated DUE TO Corroborated (c) alone DUE TO unrecognized		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Similar to her age		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) AD	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 7:00		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr. 21, 1958 , to April 27, 1958 , that I last saw the deceased alive on April 21, 1958 , and that death occurred at 11:20 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sudlersville, Md. DATE SIGNED 4/28/58			
ACTUAL SIGNATURE C. H. Metcalfe M.D.		DATE SIGNED 4/28/58	
PHYSICIAN'S NAME (Type) C. H. Metcalfe		Sudlersville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/30/58	
22c. NAME OF CEMETERY OR CREMATORY Chesterville, Md.		22d. LOCATION (City, town, or county) (State) Chesterville Kent Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Walker		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR DATE APR 30 '58		24b. REGISTRAR'S SIGNATURE W. H. Smith	

BUREAU V. 5.

APR 30 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4971

CERTIFICATE OF DEATH

04969

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE'S</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE'S</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GRASSONVILLE</u>		c. LENGTH OF STAY IN 1b <u>774</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>X GRASSONVILLE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>OLIVER COX KING</u>		4. DATE OF DEATH Month Day Year <u>APRIL 19 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH-1-1875</u>
9. AGE (In years lost birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM WELLINGTON KING</u>		14. MOTHER'S MAIDEN NAME <u>AMANDA COX</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>WILLIAM T. M. KING</u>		Address <u>5605 FAIR OAKS AVE BALTIMORE MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage + left hemiplegia</u> 331X DUE TO (b) <u>Arteriosclerotic cerebro-vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Epilepsy (grand mal)</u> DUE TO (c) <u>over 50 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>April 13.58</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Patient not seen alive was Dr. J.G. Hoyt's Queenstown Md patient</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>coroner, Dr. Fisher called no inquest necessary.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>St</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 14th</u> , 19 <u>58</u> , to <u>April 19</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>7:40 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Theodor Sattelhaier</u> M.D.		ADDRESS (Street, city or town, state) <u>Stevensville Md.</u> DATE SIGNED <u>April 21. 1958.</u>	
PHYSICIAN'S NAME (Type) <u>Theodor SATTELHAIER M.D. STEVENSVILLE Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APRIL 22-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>STEVENSVILLE</u>		22d. LOCATION (City, town, or county) (State) <u>STEVENSVILLE MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Bailey Butler</u> ADDRESS <u>Butler Rd</u>		24a. REC'D BY REGISTRAR DATE <u>APR 28 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Rebecca</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. OCCUPATION [Faint text]</p>	
<p>7. MARITAL STATUS [Faint text]</p>		<p>8. CAUSE OF DEATH [Faint text]</p>	
<p>9. MEDICAL HISTORY [Faint text]</p>		<p>10. DATE OF DEATH [Faint text]</p>	
<p>11. PLACE OF DEATH [Faint text]</p>		<p>12. SIGNATURE OF PHYSICIAN [Faint text]</p>	
<p>13. SIGNATURE OF REGISTRAR [Faint text]</p>		<p>14. SIGNATURE OF WITNESS [Faint text]</p>	

BUREAU V. S.

APR 28 1959

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04970

4972 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Centreville</u>		c. LENGTH OF STAY IN 1b <u>1</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Centreville Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lawrence</u> Middle <u>Larrimore</u> Last <u>Larrimore</u>		4. DATE OF DEATH Month <u>April</u> Day <u>27</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 9-1898</u>
9. AGE (In years lost birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (State or foreign country) <u>Delaware</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Fred Larrimore</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Stubbs</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)	
17. INFORMANT <u>Wesley Larrimore</u>		Address <u>Centreville, Md. RD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Passive Cardiac Failure</u> <u>241X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 WEEKS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchial Asthma</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Apr 23</u> , 19 <u>58</u> , to <u>Apr 26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Apr 26</u> , 19 <u>58</u> , and that death occurred at <u>3:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>MAPLE AVE.</u> DATE SIGNED <u>4-30-58</u>			
ACTUAL SIGNATURE <u>Robert H Wright</u> M.D.		PHYSICIAN'S NAME (Type) <u>ROBERT H WRIGHT GREENSBORO MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 1</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	22d. LOCATION (City, town, or county) (State) <u>Near Goldsboro, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>		ADDRESS <u>Church Hill, Md.</u>	
24a. REC'D BY REGISTRAR <u>MAY 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		65		M		W		1875		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH	
1234 E. BALTIMORE ST.		LABORER		8 YEARS		MARRIED		METHODIST		HEART DISEASE	
DATE OF DEATH		PLACE OF DEATH		TIME OF DEATH		TEMPERATURE		PULSE		BLOOD PRESSURE	
JAN 15, 1942		HOME		10:30 AM		100.0		90		120/80	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEAREST RELATIVE		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE OF DEATH		PLACE OF DEATH		TIME OF DEATH		TEMPERATURE		PULSE		BLOOD PRESSURE	
JAN 15, 1942		HOME		10:30 AM		100.0		90		120/80	

4973 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Church Hill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Church Hill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>THERESA</u> First <u>LYNN</u> Middle <u>RHODES</u> Last			4. DATE OF DEATH <u>APRIL</u> Month <u>4</u> Day <u>1958</u> Year		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 7 1958</u>	9. AGE (In years lost birthday) yrs. <u>23</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>28</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>md</u>	
13. FATHER'S NAME <u>HARRY RHODES</u>			14. MOTHER'S MAIDEN NAME <u>LILLIAN DOLORES RHODES</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>HARRY RHODES</u> Address <u>Church Hill</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Labor Pneumonia</u> 490X DUE TO (b) <u>Patient was dead when I arrived</u> Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. <u>at home</u>		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	

21. I certify that I attended the deceased from _____, 19____, to <u>April 4</u> , 19 <u>58</u> , that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>W. Henry Fisher</u>		ADDRESS (Street, city or town, state) <u>Centerville Md</u>		DATE SIGNED <u>4-5-58</u>	
PHYSICIAN'S NAME (Type) <u>W. HENRY FISHER</u>					

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>APRIL 6</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Church Hill</u>	22d. LOCATION (City, town, or county) (State) <u>md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William L. Lane</u> ADDRESS <u>Church Hill</u>		24a. REC'D BY REGISTRAR <u>APR 8 1958</u>	24b. REGISTRAR'S SIGNATURE <u>William L. Lane</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is partially filled out with handwritten text.

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		AGE	
SEX		RACE	
BIRTH DATE		BIRTH PLACE	
MARRIAGE DATE		MARRIAGE PLACE	
EDUCATION		OCCUPATION	
RELIGION		SOCIETY	
FAMILY HISTORY		PREVIOUS ILLNESS	
MEDICAL HISTORY		TREATMENT	
PATHOLOGICAL FINDINGS		LABORATORY TESTS	
POST-MORTEM EXAMINATION		BURIAL INFORMATION	

BUREAU V. 3

APR 8 1938

RECEIVED